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COMMENTS

TURNING A BLIND (WHITE) EYE IN LEGISLATING MENTAL HEALTH PARITY: THE UNMET, OVERLOOKED NEEDS OF THE WORKING POOR IN RACIAL AND ETHNIC MINORITY COMMUNITIES

Matt Boucher

“There is an eternal dispute between those who imagine the world to suit their policy, and those who correct their policy to suit the realities of the world.” *Albert Sorel*

INTRODUCTION

In terms of public awareness, 1999 was a banner year for mental health in the United States.¹ That year, then-Surgeon General David Satcher, M.D.,² released the first-ever comprehensive federal report on mental health.³ In that report, Dr. Satcher underscored the importance of mental health in our overall national public health system, sanctioned mental disorders as “real” and disabling health conditions, and reiterated the efficacy of mental health treatments.⁴ Two years

1. Generally, *mental health* may be defined as “the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity.” Conversely, *mental illness* “refers collectively to all mental disorders[, which are] health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.” DEP’T HEALTH & HUMAN SVCS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL: EXECUTIVE SUMMARY, at vii (1999)[hereinafter SGR EXECUTIVE SUMMARY].

2. Dr. Satcher resigned his post as U.S. Surgeon General in February 2002.

3. DEP’T HEALTH & HUMAN SVCS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL (1999)[HEREINAFTER SGR]. The report was supported by the collaborative efforts of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institutes of Health (NIH) and the National Institute of Mental Health (NIMH).

4. SGR EXECUTIVE SUMMARY, *supra* note 2, at vii.

later, the Surgeon General published a supplement to his initial report, which addressed specific mental health needs in the communities of American racial and ethnic minorities.⁵ Entitled *Mental Health: Culture, Race, and Ethnicity* (MHCRE), the report highlighted the “striking disparities” within the mental health care system.⁶ Various factors, including the cost of quality care and social stigma surrounding mental illness, evidence the fact that on the whole, racial and ethnic minorities in the United States carry “a greater disability burden from unmet mental health needs.”⁷

As delineated in both reports by the Surgeon General, limited access to viable care contributes to substandard levels of mental health care, particularly among racial and ethnic minorities.⁸ Although the Supreme Court has found no constitutional right to mental health care,⁹ nor is there a system of national health care,¹⁰ in recent years mental health advocates have done a commendable job lobbying for social policies that address the needs of those with mental disabilities. These advocacy efforts have been primarily geared toward eliminating discrepancies between physical and mental health care coverage in employer-sponsored insurance plans,¹¹ referred to as mental health

5. Race, as defined by the Surgeon General, refers not to biological characteristics of a people but to social characteristics held in common, such as general societal treatment and access to resources. Ethnicity “refers to a common heritage shared by a particular group.” DEP’T HEALTH & HUMAN SVCS., *MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY: A SUPPLEMENT TO MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL*, at 9 (2001)[hereinafter MHCRE].

6. For a review of the major findings of MHCRE, see Press Release, Office of Minority Health Resource Ctr., Culture Counts in Mental Health Services and Research Finds New Surgeon General Report (Aug. 26, 2001), at <http://www.omhrc.gov/omhrc/pressreleases/2001press0826.htm> (last visited Feb. 9, 2003); see also Erica Goode, *Disparities Seen in Mental Care for Minorities*, N.Y. Times, Aug. 27, 2001, at A1.

7. MHCRE, *supra* note 6, at Preface.

8. DEP’T HEALTH & HUMAN SVCS., *MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY: A SUPPLEMENT TO MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL: EXECUTIVE SUMMARY*, at 13 (2001). See also NAT’L MENTAL HEALTH ASS’N, *ACCESS TO HEALTH CARE*, at <http://www.nmha.org/position/ps28.cfm> (last visited Feb. 9, 2003).

9. See Amer. Bar Ass’n, *Mental Disability Law: A Primer*, at Part IV (John Parry ed., 6th ed. forthcoming).

10. See *infra* Part III(B).

11. “Many groups – including the National Alliance for the Mentally Ill, the National Mental Health Association, community mental health centers, and associations of psychiatrists, psychologists, and other mental health professionals –

parity.¹² Far less attention, however, has been paid to the mental health needs of the working population that lacks the advantage of such private health care coverage but which fails to qualify for public health benefit programs such as Medicaid.¹³ Racial and ethnic minorities represent a disproportionate percentage of this group.¹⁴ As stated in MHCRE:

Approximately 43 million Americans have no health insurance. Federal and State parity laws and steps to equalize health and mental health benefits in public insurance programs will do little to reduce barriers for the millions of working poor who do not qualify for public benefits, yet do not have private insurance. Today, the Nation's patchwork of health insurance programs leaves more than one person in seven with no means to pay for health care other than by out-of-pocket and charity payments. The consequences of the patchwork are many holes in the health care system through which a disproportionately greater number of poor, sick, rural, and distressed minority families frequently fall.¹⁵

[have become] increasingly vocal in denouncing the unfairness in the benefit structure and in pushing for improved health insurance coverage." Alan L. Otten, *Mental Health Parity: What Can It Accomplish in a Market Dominated by Managed Care?*, at <http://www.millbank.org/reports/mrparity.html> (last visited January 17, 2003). For an illustrative policy statement, see AMER. PSYCHIATRIC ASS'N, MENTAL HEALTH PARITY – ITS TIME HAS COME, at http://www.psych.org/pub_pol_adv/fac-parity.cfm (last visited Feb. 9, 2003).

12. Otten, *supra* note 12.

13. See generally Sara Rosenbaum, *Racial and Ethnic Disparities in Healthcare: Issues in the Design, Structure, and Administration of Federal Healthcare Financing Programs Supported Through Direct Public Funding*, in UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE 664 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003). "After 35 years, [Medicaid] remains a selective and restrictive source of coverage, reaching only approximately half of all poor individuals." *Id.* at 674.

14. See ECONOMICS & STATISTICS ADMIN., U.S. CENSUS BUREAU, PUB. NO. 60-215, HEALTH INSURANCE COVERAGE: 2000 CONSUMER REPORT (2001). See also NAT'L CTR. FOR HEALTH STATISTICS, HEALTH INSURANCE COVERAGE, at <http://www.cdc.gov/nchs/fastats/hinsure.htm> (last visited Jan. 17, 2003).

15. MHCRE, *supra* note 6, at 164.

Proponents of enhanced mental health care have too seldom recognized the needs of the working poor, focusing instead on the fervor surrounding parity laws.¹⁶

This Comment questions whether mental health parity legislation merits the vast attention it has received, maintaining that expansive community-based mental health programs should, at a minimum, coincide with lawmakers' parity efforts. Part I summarizes the findings and implications of the Surgeon General's Report of 1999 (SGR) and the MHCRE report, including discussion on the prevalence of mental illness in the United States and the disparate realities for minority communities. Part II discusses poverty and racism. Part III reveals the direct and indirect costs of mental illness and provides an economic rationale for enhanced mental health care. Part IV examines mental health parity laws, which are the principle focus of current mental health care reform. Part V probes the effectiveness of parity legislation for working-poor minorities, beginning with an analysis of public versus private spending on mental health services. Part VI concludes with a discussion of community-based alternatives to traditional mental health care, tailored to the mental health needs of select racial and ethnic minorities.

I. THE SURGEON GENERAL REPORTS AND THE NEED FOR VIRTUOUS MENTAL HEALTH CARE

A. The Surgeon General Report

One in every five Americans, about fifty-three million people, experiences a mental disorder in the course of a year.¹⁷ Having a mental disability often proves wholly debilitating — physically, emotionally, financially and socially.¹⁸ For example: chronic depression

16. For a similar argument regarding the mental health needs of the elderly, see Brian LaFratta, *Note: The Mental Health Parity Act: A Bar to Insurance Benefits for the Elderly?*, 8 Elder L. J. 393 (2000).

17. SGR EXECUTIVE SUMMARY, *supra* note 2, at xii. For an overview of the effects of general disabilities in the United States, see JOHN MCNEIL, U.S. CENSUS BUREAU, DISABILITY (Jan. 2001) at <http://www.census.gov/population/www/pop-profile/disabil.html> (last visited Jan. 17, 2003).

18. See MHCRE, *supra* note 6, at 13 (Box 1-4). See also BAZELON CTR. FOR MENTAL HEALTH LAW, A FACTUAL AND STATISTICAL REVIEW OF MENTAL HEALTH POLICY AND A QUESTIONNAIRE FOR CANDIDATES FOR PUBLIC OFFICE IN 2000, at <http://www.bazelon.org/policyreview.html> (last visited Feb. 9, 2003); E.

increases the risk of developing heart disease by four times;¹⁹ suicide is the ninth leading cause of death in the U.S.;²⁰ fifteen percent of adults with a mental illness also experience a co-occurring substance abuse disorder;²¹ between 85 to 95 percent of persons with treatable severe and persistent mental illnesses are unemployed;²² well over ten percent of the prison and jail population is afflicted with a severe mental illness;²³ one-third of homeless persons in the U.S. suffer from a mental illness;²⁴ and persons with mental illness receiving Supplemental Security Income cannot afford to rent a modest efficiency apartment in any U.S. housing market.²⁵ Plainly stated, “[s]tigma, shame, discrimination, unemployment, homelessness, criminalization, social isolation, poverty, and premature death mark the lives of most individuals with the most severe and persistent mental illnesses.”²⁶

In recognition of such alarming statistics, Dr. Satcher released his 1999 report, calling needed attention to the plaguing national public health issue of ill mental health and mental disabilities.²⁷ Drawing on

Fuller Torrey & Mary Zdanowicz, L.A. TIMES, *...and Getting Treatment Shouldn't Be This Hard*, May 27, 1999, reprinted at <http://www.psychlaws.org/GeneralResources/article13.htm> (last visited Jan. 17, 2003).

19. See Press Release, Nat'l Mental Health Ass'n, Background for the Surgeon General's Report (Dec. 9, 1999), at <http://www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=175> (last visited Feb. 10, 2003). See also NAT'L ALLIANCE FOR THE MENTALLY ILL, FACTS & FIGURES ABOUT MENTAL ILLNESS, at <http://www.nami.org/fact.htm> (last visited March 8, 2002).

20. NAT'L MENTAL HEALTH ASS'N, *supra* note 20.

21. See NAT'L MENTAL HEALTH ASS'N, DID YOU KNOW?, at <http://www.nmha.org/infoctr/didyou.cfm> (last visited Jan. 17, 2003).

22. See NAT'L ALLIANCE FOR THE MENTALLY ILL, UNTREATED MENTAL ILLNESS: A NEEDLESS HUMAN TRAGEDY, at <http://www.nami.org/update/omirabroch.html> (last visited Jan. 17, 2003).

23. *Id.* See also William Branigin & Leef Smith, *Mentally Ill Need Care, Find Prison*, WASHINGTON POST, Nov. 25, 2001, at A1.

24. NAT'L ALLIANCE FOR THE MENTALLY ILL, *supra* note 23. See also TREATMENT ADVOCACY CTR., FACT SHEET: MANY AMERICANS WITH UNTREATED PSYCHIATRIC ILLNESSES HAVE NOWHERE TO GO: HOMELESSNESS: TRAGIC SIDE EFFECT OF NON-TREATMENT, at <http://www.psychlaws.org/GeneralResources/fact11.htm> (last visited Jan. 17, 2003).

25. NAT'L ALLIANCE FOR THE MENTALLY ILL, *supra* note 23.

26. *Id.* See also TREATMENT ADVOCACY CTR., FACT SHEET: CONSEQUENCES OF NON-TREATMENT, at <http://www.psychlaws.org/GeneralResources/fact1.htm> (last visited Jan. 17, 2003).

27. See also NAT'L INSTITUTES OF HEALTH AND SUBSTANCE ABUSE AND MENTAL HEALTH SVCS. ADMIN., U.S. DEPT. OF HEALTH & HUMAN SVCS.,

over 3,000 studies in the psychological literature, the SGR presented a proliferation of research results and mental health concerns,²⁸ decisively instituting a national mental health imperative: “[T]he Surgeon General’s conviction [is] that mental health should be part of the mainstream of health.”²⁹ Moreover, the SGR facilitated the destigmatization of mental illness in American culture, a crucial component of stimulating the utilization of mental health services.³⁰

HEALTHY PEOPLE 2010: TRACKING HEALTHY PEOPLE 2010 18, (2000)(commenting on proposed target areas in the mental health field).

28. SGR EXECUTIVE SUMMARY, *supra* note 2, at vii.

29. *Id.* See also Press Release, Nat’l Mental Health Ass’n, Surgeon General’s Report Should Influence Policies (Dec. 13, 1999), at <http://www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=176> (last visited Feb. 10, 2003). “We need to get to a place in America where people see mental health as a continuum, a part of being human, and recognize that it is as important to treat mental health problems as it is physical health problems.” *Id.* (quoting Michael Faenza, President & CEO of NMHA).

30. Stigma and misinformation associated with the use of mental health care have discouraged many people from seeking mental health services. The stigmatization of mental illness is rooted in the perception, particularly in the United States, that the mentally ill are responsible for their condition....Thus, individuals who may benefit from mental health services often resist treatment in order to avoid the stigma that society attaches to mental illness.

Maria A. Morrison, *Changing Perceptions of Mental Illness and the Emergence of Expansive Mental Health Parity Legislation*, 45 S.D. L. Rev. 8, 9 (2000). See also Sharon Begley, *The Schizophrenic Mind*, Newsweek, Mar. 11, 2002, at 44; Dena Bunis, *Surgeon General Pushes Mental Health Treatment*, Salon.com (Dec. 13, 1999), at http://www.salon.com/health/log/1999/12/13/mental_health (last visited Feb. 9, 2003)(quoting Bob Carolla of the Nat’l Alliance for the Mentally Ill: “One would hope that we’ve come a long way from the myth and cliché of the Woody Allen syndrome.”); News Release, Nat’l Mental Health Ass’n, Barriers to Diagnoses for Common Mental Illnesses Could Prolong Suffering, According to New National Survey (June 6, 2001), at <http://www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=309> (last visited Feb. 9, 2003); Press Release, Nat’l Mental Health Ass’n, NMHA Poll Shows Myths & Misunderstanding Still Surround Mental Illness (June 5, 1999), at <http://www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=125> (last visited Feb. 9, 2003); TREATMENT ADVOCACY CENTER, BRIEFING PAPER: STIGMA AND VIOLENCE, at <http://www.psychlaws.org/BriefingPapers/BP9.htm> (last visited Feb. 9, 2003); Otto Wahl, *Media Madness: Public Images of Mental Illness* (Rutgers University Press 1995).

B. Mental Health: Culture, Race, and Ethnicity

In the Surgeon General's 2001 report on minority³¹ mental health,³² Dr. Satcher not only reaffirmed the messages inherent in the SGR, but also expanded a premise contained in his original report: Racial and ethnic minority populations in the U.S. have less access to mental health care than do whites,³³ are less likely to receive needed and/or quality care,³⁴ and underutilize mental health care services.³⁵ This bleak reality means that

31. MHCRE uses the term "minority" to "signify [a] group[s] limited political power and social resources, as well as their unequal access to opportunities, social rewards, and social status." MHCRE, *supra* note 6, at 5. For purposes of the MHCRE report, the four most recognized U.S. racial and ethnic minority groups were studied: African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans. Within each category, there are numerous nuances of culture (e.g., religious beliefs, nations of origin). *Id.* at 9. See *supra* note 6 on the distinction in definitions of "race" and "ethnicity."

32. The following are examples of specific findings in the report:

- Disproportionate numbers of African Americans are represented in the most vulnerable segments of the population – people who are homeless, incarcerated, in the child welfare system, victims of trauma – all populations with increased risks for mental disorders.
- As many as 40 percent of Hispanic Americans report limited English-language proficiency. Because few mental health care providers identify themselves as Spanish-speaking, most Hispanic Americans have limited access to ethnically or linguistically similar providers.
- The suicide rate among American Indians/Alaska Natives is 50 percent higher than the national rate; rates of co-occurring mental illness and substance abuse (especially alcohol) are also higher among Native youth and adults...
- Asian Americans/Pacific Islanders who seek care for a mental illness often present with more severe illnesses than do other racial or ethnic groups. This, in part, suggests that stigma and shame are critical deterrents to service utilization. It is also possible that mental illnesses may be undiagnosed or [un]treated early in their course because they are expressed in symptoms of a physical nature.

OFFICE OF MINORITY HEALTH RESOURCE CTR., *supra* note 7.

33. "This Supplement uses the term 'whites' to denote non-Hispanic white Americans." MHCRE, *supra* note 6, at 3, n.1.

34. For a gruesome illustration of the denial of treatment, see Sewell Chan & Carol Leonnig, *D.C. Sent Man Away Before Killing*, WASHINGTON POST, Mar. 3, 2002, at C1.

35. MHCRE, *supra* note 6, at 3. According to a 2000 study conducted by the National Mental Health Association, "Misdiagnosis and inadequate treatment

[R]acial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their overall health and productivity... Because of preventable disparities in mental health services, a disproportionate number of minorities are not fully benefiting from, or contributing to, the opportunities and prosperity of our society.³⁶

The lack of access to proper, effective mental health treatment for select minorities has a damaging effect on the nation's overall well-being, resulting in "poor outcomes, disrupted families, lost productivity and higher overall health expenditures."³⁷

II. POVERTY AND RACISM: INVITING RISK FOR MENTAL DISORDER

Notwithstanding the fact that racial and ethnic minorities face limited access to mental health services, the *need* for such services is, in fact, generally more acute. This is due, in large measure, to social adversities prevalent in such communities.³⁸ For minorities in lower socioeconomic strata (SES), the psychological consequences of poverty and racism place them at greater risk for mental disorders than whites.³⁹ Indeed, throughout MCHRE, Dr. Satcher repeatedly refers to minorities as "among the Nation's vulnerable, high-need groups."⁴⁰

often occurs in minority communities. Factors that can contribute include a general mistrust of medical health professionals, cultural barriers, co-occurring disorders, socioeconomic factors, and primary reliance on family and the religious community during times of distress." NAT'L MENTAL HEALTH ASS'N, *supra* note 22.

36. MCHRE, *supra* note 6, at 3. For a well-informed paper on targeting the mental health needs of minority women, see NAT'L MENTAL HEALTH ASS'N, MEETING THE CHALLENGE: ENDING TREATMENT DISPARITIES FOR WOMEN OF COLOR, at http://www.nmha.org/substance/women_disparities.cfm (last visited Jan. 16, 2003).

37. BAZELON CTR. FOR MENTAL HEALTH LAW, *supra* note 19, at 2.

38. MCHRE, *supra* note 6, at 167. "Mental health is adversely affected by chronic social conditions that disproportionately affect America's poor and its racial and ethnic minority groups. These conditions include poverty, community violence, racism, and discrimination." *Id.*

39. *Id.* at 38-39.

40. *Id.* at 3.

A. Poverty

As discussed at length in MHCRE, there is said to be a causal relationship between poverty and inferior health conditions, including ill mental health.⁴¹

Studies have consistently shown that people in the lowest strata of income, education, and occupation (known as socioeconomic status, or SES) are about two to three times more likely than those in the highest strata to have a mental disorder... They are also more likely to have higher levels of psychological distress.⁴²

Poverty increases exposure to “stressful social environments (e.g., violence and unemployment).”⁴³ Constant exposure to these stressors “ups the ante” for the likelihood of a mental disorder. The fact that racial and ethnic minorities are more likely than whites to be poor or near poor⁴⁴ - and thus more frequently exposed to psychological

41. *Id.* at 39. “For centuries, it has been known that people living in poverty, whatever their race or ethnicity, have the poorest overall health...It comes as no surprise then that poverty is also linked to poorer mental health.” *Id.* (citations omitted). What’s more, mental illness may itself sometimes be the *cause* of poverty. “[H]aving a mental disorder, such as schizophrenia, takes such a toll on individual functioning and productivity that it can lead to poverty. In this way, poverty is a consequence of mental illness.” *Id.* at 40 (citations omitted).

42. *Id.* at 39 (citations omitted).

43. *Id.* at 39-40. “People who are poor are more likely to be exposed to stressful social environments (e.g., violence and unemployment) and to be cushioned less by social or material resources. In this way, poverty among whites and nonwhites is a risk factor for poor mental health.” *Id.* (citations omitted).

44. *Id.* at 39. Poverty disproportionately affects racial and ethnic minorities. The overall rate of poverty in the United States, 12 percent in 1999, masks great variation. While 8 percent of whites are poor, rates are much higher among racial and ethnic minorities: 11 percent of Asian Americans and Pacific Islanders, 23 percent of Hispanic Americans, 24 percent of African Americans, and 26 percent of American Indians and Alaska Natives. Measured another way, the per capita income for racial and ethnic minority groups is much lower than that for whites. *Id.* at 39. (citations omitted). See also INST. FOR RESEARCH ON POVERTY, HOW IS POVERTY MEASURED IN THE UNITED STATES?, at <http://www.ssc.wisc.edu/irp/faqs/faq2.htm> (last visited Jan. 17, 2003); INST. FOR RESEARCH ON POVERTY, WHO WAS POOR IN 2001?, at <http://www.ssc.wisc.edu/irp/faqs/faq3.htm> (last visited Jan. 17, 2003); U.S. CENSUS BUREAU, POVERTY: 2000 HIGHLIGHTS, at <http://www.census.gov/hhes/poverty/poverty00/pov00hi.html> (last visited Jan. 17, 2003).

stressors - suggests that these communities represent a population at a higher risk for deficient mental health.⁴⁵

B. Racism

Inexorably linked to poverty are the ills of racism and discrimination,⁴⁶ which place minorities “*at risk for mental disorders such as depression and anxiety.*”⁴⁷ It is unclear whether racism and discrimination in and of themselves can create mental disorders.⁴⁸ Parsing the effects of SES from cultural differences in health is a difficult, ongoing scholastic argument.⁴⁹ Countless articles have examined the “nature-nurture” health care debate. Such a debate is beyond the scope of this Comment, but the bottom line is that “[r]acism and discrimination by societal institutions have resulted in minorities’ lower socioeconomic status and poorer living conditions in which poverty, crime, and violence are persistent stressors that can affect mental health.”⁵⁰

1. A Caveat

Despite the foregoing implications of poverty and racism, strong emphasis should be placed on the Surgeon General’s MHCRC finding that “*overall prevalence rates for mental disorders in the United States are similar across minority and majority populations.*”⁵¹ One of the dangers in releasing reports such as MHCRC is that the general public may assume that minorities on the whole are more mentally ill than are whites. This is categorically false.⁵² As indicated throughout the

45. MHCRC, *supra* note 6, at 39-40. Given that minority communities generally encounter more stressors than do white communities but overall mental disorder prevalence rates are comparable, the argument has been made that minorities may in fact be more psychologically resilient than whites, as minorities have, de facto, been forced to devise more coping mechanisms. “[M]inority groups have developed coping skills to help them endure [the damaging effects of] generations of poverty.” *Id.* at 40.

46. See *id.* at 37-38 for a brief discussion of discrimination: “Recent studies link the experience of racism to poorer mental and physical health.” *Id.* at 38.

47. *Id.* at 38 (emphasis original).

48. *Id.*

49. *Id.* at 40.

50. *Id.* at 39.

51. *Id.* at 27 (emphasis in original).

52. See NAT’L MENTAL HEALTH ASS’N., *supra* note 22. The prevalence of illicit drug use, however, has been found to be higher among Native Americans (10.6 percent), African Americans (7.7 percent) and Hispanics (6.8 percent) than

MHRCE, many psychological and psychiatric studies are grossly inadequate in terms of demographic accounting.⁵³ However, enough evidence exists to support the finding that the prevalence of mental illness among minorities is analogous to that prevalence within the entire U.S. population (approximately 21 percent).⁵⁴

C. Working-Poor Minorities

The public health sector, through programs such as Medicaid,⁵⁵ often provides the avenue to mental health care for minorities in low SES groups.⁵⁶ Yet many of the working poor in these communities are unable to qualify for publicly funded health programs. For example, Medicaid covered only 37% of non-elderly Americans with incomes below the poverty level in 1999.⁵⁷ Among the working-poor minorities

among whites (6.6 percent). The prevalence rate for Asian Americans is a lower 3.2 percent. *Id.*

53. MHRCE, *supra* note 6, at 17-18. See also Rene Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79 (2001)(suggesting that race-based profiling exists in health care services and influences the clinical judgment of providers).

54. MHRCE, *supra* note 6, at 7. The exception to this may be the prevalence of mental disorders among American Indians and Alaska Natives, which has been reported in excess of 30 percent, but the scant amount of viable research limits the credibility of this statistic. *Id.* at 85.

55. For a discussion of Medicaid, see *infra* note 58. Because this Comment focuses on the *working* poor, consideration is not given to Medicare, a federal health program primarily geared toward those 65 years and older.

56. MHRCE, *supra* note 6, at 63. "Medicaid was the most widespread type of health insurance among the poor, with 39.9 percent (12.9 million) of those in poverty covered by Medicaid for some or all of 1999." U.S. Census Bureau, *supra* note 15, at 3. See also MHRCE, *supra* note 6, at 63, 91, 117-18, 141-42. But see TREATMENT ADVOCACY CTR., FACT SHEET: MEDICAID DISCRIMINATION AGAINST THE SEVERELY MENTALLY ILL, at <http://www.psychlaws.org/GeneralResources/fact12.htm> (last visited Jan. 20, 2003)(discussing Medicaid's denial of coverage to the severely mentally ill).

57. Jane Perkins, *Symposium: Barriers to Access to Health Care: Medicaid: Past Successes and Future Challenges*, 12 HEALTH MATRIX 7 (2002). Medicaid is a cooperative federal-state program that, generally, provides health care coverage for the disadvantaged. Certain eligibility groups automatically qualify for coverage. It is left to the individual states to determine eligibility for groups not mandated by federal law, such as the non-elderly, working poor. Thus, it is altogether possible to be poor, though employed, and fall short of Medicaid eligibility. See Scott Harris, *Waiting Room*, Salon.com (Oct. 21, 1999), at <http://www.salon.com/health/feature/1999/10/21/uninsured/print.html> (last visited Jan. 20, 2003). "A study released last

without public or private insurance, those suffering from mental disorders are at a particular disadvantage, for they have a greater chance of developing a mental disability and a lesser chance of adequately addressing it. Disabled “three times over,”⁵⁸ this population is, unquestionably, “not fully benefiting from, or contributing to, the opportunities and prosperity of our society.”⁵⁹ Consequently, bolstering community treatment programs, which render both *attentive* and *preventive* mental health care to the uninsured, would allow this population to work more effectively and live more fully. This proposition is well grounded in economic sensibilities⁶⁰ and, more significantly, humanitarian principles of equality and fairness.⁶¹

III. THE COSTS OF MENTAL ILLNESS

In laying the groundwork for the SGR, the Surgeon General utilized a study conducted in the mid-1990s by the World Health Organization.⁶² This study measured the “burden of disability” in

summer by the nonpartisan Henry J. Kaiser Family Foundation showed that 84 percent of the uninsured are from families that have a member working full-time or part-time... Moreover, most new jobs in America’s evolving economy are in small firms less likely to offer health plans.” *Id.* For a helpful synopsis of Medicaid eligibility and benefits, see CTRS. FOR MEDICARE & MEDICAID SVCS, *MEDICAID: A BRIEF SUMMARY*, at <http://cms.hhs.gov/publications/overviewmedicaremedicaid/default4.asp> (last visited Jan. 17, 2003); see also Rosenbaum, *supra* note 14; Sara Rosenbaum & David Rousseau, *Symposium: Medicaid at Thirty-Five*, 45 ST. LOUIS L. J. 7 (2001).

58. I.e., by their mental disability, by their poverty, and by the ills of racism and discrimination.

59. MHCRE, *supra* note 6, at 3.

60. See discussion *infra* Part II.

61. This Comment holds an admittedly egalitarian orientation to health care, emphasizing the virtues of social justice. Naturally, there are other approaches, such as libertarianism, to be considered. For a brilliant examination of the guiding philosophical principles specific to mental health care policy decisionmaking, see Daniel Chisholm & Alan Stewart, *Economics and Ethics in Mental Health Care: Traditions and Trade-offs*, 1 J. MENTAL HEALTH POL’Y & ECON 55 (1998); see also Madison Powers & Ruth Faden, *Racial and Ethnic Disparities in Healthcare: An Ethical Analysis of When and How They Matter*, in UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE 722 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003).

62. SGR EXECUTIVE SUMMARY, *supra* note 2, at viii. The study was undertaken in collaboration with the World Bank and Harvard University.

established market economies throughout the world.⁶³ The Global Burden of Disease study calculated “disability-adjusted life years” (DALYs) by examining years of life lost to premature death and years lived with a disability of specified severity and duration.⁶⁴ When studied specifically with respect to mental health, DALYs reflected “the impact of mental illness on overall health and productivity.”⁶⁵ The results were profound in several respects, not the least of which was that mental illness ranked as the second leading cause of disability and premature mortality.⁶⁶ As reported in the SGR Executive Summary, “[m]ental disorders collectively account for more than 15 percent of the overall burden of disease from *all* causes and slightly more than the burden associated with all forms of cancer.”⁶⁷

These statistics derived from the Global Burden of Disease study buttress the SGR’s findings on the profound costs of mental illness in the United States. According to the report, the U.S. economy suffered a nearly \$79 billion loss in 1990 from the indirect costs of mental illness.⁶⁸ Conversely, direct costs, meaning actual mental health

63. *Id.* at ix. See generally THE GLOBAL BURDEN OF DISEASE: A COMPREHENSIVE ASSESSMENT OF MORTALITY AND DISABILITY FROM DISEASES, INJURIES, AND RISK FACTORS IN 1990 AND PROJECTED IN 2020 (C.L. Murray & A.D. Lopez eds., Harvard University, 1996). For further detail of the study, visit the *Global Burden of Disease* web site, at <http://www.who.int/msa/mnh/ems/dalys/intro.htm> (last visited Feb. 9, 2003).

64. SGR EXECUTIVE SUMMARY, *supra* note 2, at ix.

65. *Id.* The leading cause was cardiovascular conditions.

66. *Id.* See also Chartbook on Work and Disability, Section 3: What Chronic Health Conditions Most Frequently Cause Work Limitation?, at http://www.infouse.com/disabilitydata/workdisability_3_2.html (last visited Jan. 21, 2003).

67. SGR EXECUTIVE SUMMARY, *supra* note 2, at ix. (emphasis in original). It should be noted that for purposes of the study, suicide was included in calculating the disease burden of mental illness.

68. SGR, *supra* note 4, at 411. The report scrutinized the costs as follows:

Most of that amount (\$63 billion) reflects morbidity costs—the loss of productivity in usual activities because of illness. But indirect costs also include almost \$12 billion in mortality costs (lost productivity due to premature death), and almost \$4 billion in productivity losses for incarcerated individuals and for the time of individuals providing family care. For schizophrenia alone, the total indirect cost was almost \$15 billion in 1990.

Id. Notably, the SGR goes on to state that, “[t]hese indirect cost estimates are conservative because they do not capture some measure of the pain, suffering, disruption, and reduced productivity that are not reflected in earnings.” *Id.*

treatment and rehabilitation expenses,⁶⁹ speak to health care providers and supplemental government costs.⁷⁰ Of the \$943 billion spent on direct health care costs in 1996, \$99 billion went toward mental health services.⁷¹ More than seven percent of the total health care cost (roughly \$69 of \$943 billion) was consumed by treatment for mental disorders, with an additional three percent (\$31 billion) spent on dementia and addiction disorders.⁷² Thus, the annual aggregate expense (i.e., indirect and direct costs) for mental health care averaged approximately \$180 billion in the last decade.⁷³

Only 15 percent of the adult U.S. population utilizes the *de facto* mental health service system.⁷⁴ Skeptics of expansive mental health care coverage reform in the private sector argue that providing for wider utilization of mental health services will grossly enlarge annual spending.⁷⁵ While a spending increase is undeniably necessary for better mental health care, proponents argue, correctly, that if more preventative measures in mental health care are taken, a less disabling impact will be felt by the repercussions of mental illness.⁷⁶ For

69. *Id.* at 412.

70. In 1996, 53 percent of the cost of mental health care was covered by public payers (State, Federal, Medicaid and Medicare), while private payers (private insurance, out-of-pocket and "other" private sources) covered the other 47 percent. *Id.* at 413. And although "spending for mental health care has declined as a percentage of overall health spending over the past decade. . . public payers have increased their share of total mental health spending." *Id.* at 417.

71. *Id.* at 412.

72. *Id.*, but see n.3 (discussing different results in D.P. Rice, S. Kelman, L.S. Miller & S. Dunmeyer, *The Economic Costs of Alcohol and Drug Abuse and Mental Illness* (Institute for Health and Aging 1985)).

73. Because the indirect cost figure (\$79 billion) derived from 1990 statistics and the direct cost figure (\$99 billion) from 1996 statistics, \$180 may be not be an entirely accurate representation, due to inflation and market instability. Nonetheless, these figures provide a "ballpark" idea of annual expenditures for the U.S. in the 1990s.

74. The Surgeon General lists four sectors which comprise the *de facto* U.S. mental health service system: the specialty mental health, general medical/primary care, human services, and voluntary support network sectors. SGR, *supra* note 4, at 405-406.

75. See *infra* note 87.

76. This argument is typically made to advance private insurance parity laws, although the same is true for public-sector mental health care. See also MHCRC, *supra* note 6, at 165: "Engaging and treating racial and ethnic minority children, adults, or older adults...may require a greater initial investment of resources, but it may also result in substantial decreases in disability burden."

example, a 1993 study by the National Advisory Mental Health Council reported that providing mental health coverage commensurate to physical health coverage for all children and adults would save \$2.2 billion annually in general medical services and indirect costs.⁷⁷ In other words, pouring more money into direct costs will lower indirect costs, with a greater rate of return.⁷⁸

IV. MENTAL HEALTH PARITY LAWS

The above data demonstrate the clear need to devise cost-saving measures for U.S. mental health care. Over the past several decades, legislators, both in growing recognition of mental illness as a legitimate medical illness and as a means to increase national savings,⁷⁹ have enacted multitudinous state and federal laws bolstering mental health services. Foremost among these legislative overhauls has been the rise of mental health parity — governmental efforts to close the gap between mental health service financing and general health service financing among private insurers.⁸⁰

A. The Historical Underpinnings of Discrepant Mental Health Coverage Among Private Insurers

According to the SGR, “[p]rivate health insurance is generally more restrictive in coverage of mental illness than in coverage for somatic

77. NAT'L ADVISORY MENTAL HEALTH COUNCIL, DEP'T HEALTH & HUMAN SVCS., *PARITY IN COVERAGE OF MENTAL HEALTH SERVICES IN AN ERA OF MANAGED CARE*, (1997). See also NAT'L MENTAL HEALTH ASS'N, *WHY MENTAL HEALTH PARITY MAKES ECONOMIC SENSE*, at http://www.nmha.org/state/parity/parity_economy.cfm (last visited Jan. 20, 2003). Further, a 1999 study conducted by the Office of National Drug Control Policy found that “[f]or each dollar invested in treatment, studies have found a four to seven dollar cost-savings on crime and criminal justice costs.” *Id.*

78. See NAT'L MENTAL HEALTH ASS'N, *MENTAL HEALTH: PAY FOR SERVICES OR PAY A GREATER PRICE*, at <http://www.nmha.org/federal/appropriations/index.cfm> (last visited Jan. 20, 2003).

79. Morrison, *supra* note 31, at 11.

80. See generally Richard Gardner, III, *Comment: Mind Over Matter?: The Historical Search for Meaningful Parity Between Mental and Physical Health Care Coverage*, 49 Emory L.J. 675 (2000).

illness” for several reasons.⁸¹ Insurers have long believed that ongoing mental health care, intensive psychotherapy and extended inpatient hospitalizations result in tremendous cost increases.⁸² Furthermore, private insurers, knowing that the public mental health system existed as a “safety net”⁸³ for those whose benefits expired, were reluctant to offer generous mental health plans.⁸⁴

Consequently, some private insurers

refused to cover mental illness treatment [entirely]; others simply limited payment to acute care services. Those who did offer coverage chose to impose various financial restrictions, such as separate and lower annual and lifetime limits on care (per person and per episode of care), as well as separate (and higher) deductibles and copayments. As a result, individuals paid out-of-pocket for a higher proportion of mental health services than general health services and faced catastrophic financial losses (and/or transfer to the public sector) when the costs of their care exceeded the limits.⁸⁵

However, as this trend continued, studies began to show insurers’ suspicions regarding the costs of mental health care to be unfounded.⁸⁶ Moreover, as other studies have generated findings of impressive efficacy for mental illness treatments,⁸⁷ public perceptions have begun to shift, and mental illness is gradually losing its stigma.⁸⁸

81. SGR, *supra* note 4, at 418.

82. *Id.*

83. *See infra* Part IV(A).

84. SGR, *supra* note 4, at 418.

85. *Id.*

86. A 2000 study found that only 3 percent of businesses reported a cost increase in response to the MHPA. *See* News Release, Nat’l Mental Health Ass’n, Report from GAO, Surgeon General Show Necessity of Real Parity Laws (May 18, 2000), at <http://www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=203> (last visited Feb. 9, 2003). These data correspond with data derived from studies of states with inclusive mental health parity statutes. For example, in Vermont, Maryland and Minnesota, which all have comprehensive parity, “health insurance costs increased less than one percent after implementation.” *Id.* *See also* Morrison, *supra* note 31, at 22-26; NAT’L ALLIANCE FOR THE MENTALLY ILL, THE COST OF MENTAL ILLNESS INSURANCE PARITY, at <http://www.nami.org/update/insparity.html> (last visited Feb. 9, 2003); Roland Sturm, The Costs of Covering Mental Health and Substance Abuse at the Same Level as Medical Care in Private Insurance Plans, at <http://www.rand.org/publications/CT/CT180/CT180.pdf> (last visited Feb. 9, 2003).

87. Notably, the SGR.

88. *See supra* note 31.

Consequently, the demand for mental health services has increased,⁸⁹ at least among those who carry private insurance benefits, and health insurers are becoming less likely to exclude mental health coverage from their plans. Yet, as parity proponents maintain, nothing short of a legislative mandate will guarantee equal coverage.⁹⁰

B. Recent Federal Parity Legislation

The failed 1993 Clinton health care plan, entitled the *American Health Security Act* (AHSA),⁹¹ would have eliminated disparities in mental health coverage.⁹² In response to the collapse of AHSA, lawmakers favoring nationalized health care have piecemealed portions of AHSA into effect.⁹³ Demonstrating the demand for, and cost benefits of, mental health parity has added merit to the AHSA's agenda for better mental health care coverage. Accordingly, there has been increased federal and state momentum toward corresponding legislation.⁹⁴

89. See Morrison, *supra* note 31, at 8-9. See also Jeffrey Rubin, *Issues in the Financing and Organization of Mental Health Services*, in MENTAL HEALTH AND LAW: RESEARCH, POLICY AND SERVICES 246 (Bruce D. Sales & Saleem A. Shah eds., 1996).

90. See News Release, Nat'l Mental Health Ass'n, It's Time to End the Discrimination and the Myths: Business Groups and Scientologists Combine Forces to Kill Parity (Nov. 29, 2001), at <http://www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=365> (last visited Feb. 10, 2003).

91. American Health Security Act, H.R./S., 103d Cong., 1st Sess. (1993), reprinted in President Clinton's Health Care Reform and Health Security Act as Presented to Congress on October 27, 1993 (Commerce Clearing House 1993); The President's Health Security Plan (Random House 1993).

92. See M. Susan Ridgely & Howard Goldman, *Symposium: Putting the "Failure" of National Health Care Reform in Perspective: Mental Health Benefits and the "Benefit" of Incrementalism*, 40 ST. LOUIS L.J. 407, 425-28 (1996). But see Madeleine Pelter Cosman, *Psychiatric Darwinism = Survival of the Fittest + Extinction of the Unfit*, 17 ISSUES L. & MED. 3 (2001), for a harsh critique of the mental health plan of AHSA.

93. Examples include the *Health Insurance Portability and Accountability Act* and Section 4507 of the *Balanced Budget Act* of 1997. Cosman, *supra* note 93, at 4.

94. SGR, *supra* note 4, at 427. For example, all federal employees are now entitled, by law, to mental health parity benefits.

The initial⁹⁵ Congressional attempt at ensuring equal coverage in private insurance for mental and physical illness was the Mental Health Parity Act of 1996 (MHPA). Implemented in 1998,⁹⁶ the MHPA effectively “barred larger private-sector health plans from imposing lower annual or lifetime *dollar* limits on mental health benefits than on physical health benefits.”⁹⁷ While hailed by mental health advocates as an important first step toward equality in mental health care, the bill left many loopholes for private insurers, as it failed to address issues such as limits on inpatient days, outpatient visits and out-of-pocket consumer costs.⁹⁸ More importantly, the bill did not require mental health coverage for those plans which did not already offer mental health benefits, nor did it mandate parity for alcohol and substance abuse treatment.⁹⁹ Additionally, the MHPA exempted businesses with 50 or fewer employees and businesses that could prove retrospectively that compliance with the bill increased their health plan costs by more than one percent,¹⁰⁰ a provision designed to appease those parity opponents who argued that broader mental health coverage would drive up costs immeasurably.¹⁰¹

In addition to the above shortcomings, the MHPA also included a September 30, 2001 sunset provision.¹⁰² Accordingly, Senators Domenici (R-NM) and Wellstone (D-Minn.),¹⁰³ the originators of the MHPA, introduced the Mental Health Equitable Treatment Act

95. “Initial” for purposes of this Comment, as the Mental Health Parity Act of 1996 is, historically, the most significant federal parity law. Yet federal efforts to legislate parity actually date from the 1970s. SGR, *supra* note 4, at 427.

96. Mental Health Parity Act of 1996, Pub. L. No. 104-204, Title VII, § 702(a), 110 Stat. 2944 (Sept. 26, 1996). For a comprehensive summary of the MHPA, see CTR. FOR MENTAL HEALTH SVCS, MENTAL HEALTH PARITY ACT SUMMARY, at <http://www.mentalhealth.org/cmhs/ManagedCare/Parity/Summary.asp> (last visited Jan. 17, 2003).

97. BAZELON CTR. FOR MENTAL HEALTH LAW, *supra* note 19, at 3 (emphasis original).

98. *Id.*

99. 29 U.S.C. § 1185a(b)(1)(2000). See also *infra* note 105.

100. BAZELON CTR. FOR MENTAL HEALTH LAW, *supra* note 19, at 3.

101. See *supra* note 87.

102. 29 U.S.C. § 1185a(f)(2000).

103. Federal parity efforts have been notably bipartisan. However, Sen. Wellstone has been critical of President Bush’s lack of support for the bill, saying that the White House has been “of no help.” See Robert Pear, *Ideas & Trends, Minds Over Money*, N.Y. TIMES, Dec. 30, 2001, § 4, at 4.

(MHETA) in Spring 2001.¹⁰⁴ The MHETA not only upheld the directives of the MHPA, but also expanded parity coverage to include *all* categories of conditions listed in the *Diagnostic and Statistical Manual of Mental Disorders*.¹⁰⁵ Additionally, the MHETA eliminated the MHPA exemption available to businesses that show an increase of more than one percent in health coverage costs.¹⁰⁶ To the dismay of mental health advocates,¹⁰⁷ however, House members rejected the Senate's MHETA proposal on December 17, 2001.¹⁰⁸ Consequently, no

104. S. 543, 107th Cong. (2001). The bill was to be an amendment to the FY2002 Labor, Health and Human Services and Education Appropriations Bill, a \$396 billion spending bill.

At the same time Senators Dominici and Wellstone were introducing the MHETA to the Senate, Representative Marge Roukema (R-NJ) introduced a counterpart bill to the House, H.R. 162, entitled the "Mental Health and Substance Abuse Parity Amendments of 2001." Mental health lobbyists favored Rep. Roukema's bill to the MHETA, primarily because it includes parity for substance abuse treatment. *See also* Kevin D. Hennessy & Howard H. Goldman, *Full Parity: Steps Toward Treatment Equity for Mental and Addictive Disorders*, 20 HEALTH AFFAIRS 58 (2001).

105. AM. PSYCHOL. ASS'N., *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION (DSM-IV)* (1993). Previously, under the MHPA, only "severe mental disorders" as listed in the *DSM-IV*, such as schizophrenia and bipolar disorder, were subject to parity provisions. The MHETA broadened the scope of the law to include disorders such as anorexia and bulimia, post-traumatic stress disorder and serious mental and emotional disorders among children. Interestingly, although alcohol and chemical dependency are listed as existing disorders in the *DSM-IV*, the MHETA, like its predecessor, excludes substance abuse treatment from its mental health benefits provision (S. 543(f)(3)). *See* discussion of H.R. 162 *supra* note 105.

106. Yet the bill's final draft struck its original wording that would have prohibited insurance plans from imposing limits on inpatient days, outpatient visits and out-of-pocket consumer costs.

107. *See* Press Release, Nat'l Alliance for the Mentally Ill, The President, Congress, and the Mental Health Parity Amendment: Let's Hold the Leaders Who Killed It Accountable (Dec. 18, 2001), at <http://www.nami.org/cgi-bin/printfy.cgi?pressroom/20011218.html> (last visited Feb. 9, 2003); Press Release, Nat'l Mental Health Ass'n, Defeat Fuels Determination to Win Parity Battle (Dec. 18, 2001), at <http://www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=374> (last visited Feb. 9, 2003).

108. Robert Pear, *Drive for More Mental Health Coverage Fails in Congress*, N.Y. TIMES, Dec. 18, 2001, at A20: "House Republicans, employers and insurance companies rejected the proposal, saying it would increase costs for employers in a recession, when many businesses are already cutting health benefits because of a

federal parity mandate for employee-sponsored insurance plans exists at present,¹⁰⁹ although the parity issue is likely to be revived in the 108th Congress.¹¹⁰

C. Impediments to Parity

Advocates maintain that the attention drawn to federal mental health parity activity may pave the way for more extensive legislation in the future.¹¹¹ They further argue that federal parity efforts will prompt states without parity legislation to enact such statutes.¹¹² While more states are, in fact, adopting parity laws, the Employee Retirement Income Security Act (ERISA) of 1974 substantially limits the actual population to which these mandates apply.¹¹³ ERISA restricts fully self-insured employee benefit plans by preempting state-mandated benefit laws.¹¹⁴

resurgence in medical inflation." See also Abigail Trafford, *Writing Off Depression*, WASHINGTON POST, Jan. 1, 2002, at F1.

109. For an exhaustive overview of mental health parity, see HAROLD VARMUS, NAT'L INSTITUTES OF HEALTH, NIHM PARITY IN FINANCING MENTAL HEALTH SERVICES: MANAGED CARE EFFECTS ON COST, ACCESS, AND QUALITY (1998).

110. The newly dubbed "Paul Wellstone Mental Health Parity Act," named in honor of the late Senator, is expected for reintroduction in February 2003. See NAT'L MENTAL HEALTH ASS'N, PARITY BILLS SET FOR INTRODUCTION THIS MONTH, at <http://www.nmha.org/newsroom/system/lal.vw.cfm?do=vw&rid=485> (last visited Feb. 9, 2003).

111. See Otten, *supra* note 12.

112. See NAT'L MENTAL HEALTH ASS'N, WHAT HAVE STATES DONE TO ENSURE HEALTH INSURANCE PARITY?, at http://www.nmha.org/state/parity/state_parity.cfm (last visited Jan. 14, 2003). Presently, eighteen states are yet to institute mental health parity laws, and twenty-five states have parity laws that apply only to select groups, such as those with severe mental illnesses or state and local employees. Eight states have comprehensive or full parity laws that are more inclusive and comprehensive than federal parity mandates: Connecticut, Maryland, Minnesota and Vermont have comprehensive parity for all, including mental health and substance abuse. Rhode Island, Indiana, New Mexico and Kentucky offer full parity, but have certain exemptions and/or limitations in coverage, most often for substance abuse treatment. *Id.*

113. Keith Nelson, *Comment: Legislative and Judicial Solutions for Mental Health Parity: S. 543, Reasonable Accommodation, and an Individualized Remedy Under Title I of the ADA*, 51 AM. U. L. REV. 91, 100 (2001).

114. *Id.* at 101. See also Blaine Hummel, *Note: The Duty of Ordinary Care for HMOs: Can Texas Senate Bill 386 Weather the Storm of ERISA Preemption?*, 18 REV. LITIG. 649 (1999)(providing an adept overview of ERISA preemption

Another barrier to mental health parity has been the judicial response to the innumerable lawsuits against insurers who fail to provide adequate parity for mental health benefits or mental health benefits at all. These legal challenges, brought primarily under the auspices of the Americans With Disabilities Act (ADA), "have been largely futile, with numerous federal courts across the country unanimously holding that lesser coverage for mental illnesses in health and disability benefits is neither discriminatory nor illegal."¹¹⁵ Generally, mental health coverage litigation rarely favors the individual plaintiff.¹¹⁶

Finally, there is myriad literature analyzing the impact of managed care on mental health treatment.¹¹⁷ Commentators have noted several

regulations); Brian Shannon, *Paving the Path to Parity in Health Insurance Coverage for Mental Illness: New Law or Merely Good Intentions?*, 68 U. COLO. L. REV. 63, 77 (1997). *But see* *Unum Life Ins. Co. of Am. v. Ward*, 119 S. Ct. 1380 (1999)(ruling unanimously that where insurance is regulated by state law generally, rather than employment benefits specifically, ERISA does not preempt state law).

115. Nelson, *supra* note 114, at 95. *See also* Alexander Abbe, *Comment: "Meaningful Access" to Health Care and the Remedies Available to Medicaid Managed Care Recipients Under the ADA and the Rehabilitation Act*, 147 U. PA. L. REV. 1161 (1999); Nancy Lee Firak, *Threshold Barriers to Title I and Title III of the Americans with Disabilities Act: Discrimination Against Mental Illness in Long-Term Disability Benefits*, 12 J.L. & HEALTH 205 (1997/1998); Maggie Gold, *Must Insurers Treat All Illnesses Equally? – Mental vs. Physical Illness: Congressional and Administrative Failure to End Limitations to and Exclusions from Coverage for Mental Illness in Employer-Provided Health Benefits Under the Mental Health Parity Act and the Americans with Disabilities Act*, 4 CONN. INS. L.J. 767 (1997/1998); Christopher Aaron Jones, *Special Project: Current Issues in Mental Health Care: Legislative "Subterfuge"?: Failing to Insure Persons with Mental Illness Under the Mental Health Parity Act and the Americans with Disabilities Act*, 50 VAND. L. REV. 753 (1997); Donna Orzell, *Note: The Toleration of Unjustified Distinctions Between the Mentally and Physically Disabled in Lewis v. Kmart Corp. Makes One Thing Clear: Not All Disabilities Were Created Equal*, 45 VILL. L. REV. 517 (2000); Diane Serritella, *Select Recent Court Decisions: Disability & ADA: Employers and Insurers Not Obligated by the ADA to Provide Equal Benefit Plans for Physical and Mental Disabilities*, 26 AM. J. L. & MED. (2000); Pamela Signorello, *Note: The Failure of the ADA – Achieving Parity with Respect to Mental and Physical Health Care Coverage in the Private Employment Realm*, 10 CORNELL J. L. & PUB. POL'Y 349 (2001)).

116. *But see* *Fitts v. Fannie Mae*, 191 F.Supp.2d (D.C. 2002)(finding that defendant insurance company improperly classified an employee's bipolar disorder as a mental rather than physical illness).

117. *See generally* Otten, *supra* note 12; Philip Boyle, *Symposium: Managed Care in Mental Health: A Cure, or a Cure Worse Than the Disease?*, 40 ST. LOUIS L.

potential conflicts between managed care programs and mental health care quality, including "limitations on patients' choices of providers and treatments, reductions in quality and access to care, and disruptions of the provider-patient relationship."¹¹⁸ At the same time, there is also discussion of the negative side effects of the interplay between managed care and mental health parity laws.¹¹⁹

Thus, parity legislation, though laudable for its efforts to achieve equality, is not in and of itself without flaw. First, many loopholes for employers exist within the legislative language itself. Second, impediments to parity - ERISA preemption, recent ADA litigation and the barriers of managed care - should be noted. A third consideration is the very basic fact - so elementary and so often overlooked - that parity laws extend better mental health care *only* to those advantaged with employer-sponsored insurance benefits. As a result, parity "misses the mark" for America's working poor, many of whom are minorities and many of whom lack health care coverage.

V. THE DISJOINT OF PARITY LAWS RELATIVE TO THE MENTAL HEALTH NEEDS OF WORKING-POOR MINORITIES

A. The Safety Net

The public sector is the primary source of funding for mental health services.¹²⁰ In 1996, private insurance accounted for only 27 percent of

J. 437 (1996); Jesse Goldner, *Managed Care and Mental Health: Clinical Perspectives and Legal Realities*, 35 HOUS. L. REV. 1437 (1999); BAZELON CTR. FOR MENTAL HEALTH LAW, MANAGING MANAGED CARE FOR PUBLICLY FINANCED MENTAL HEALTH SERVICES, at <http://www.bazelon.org/issues/managedcare/resources/public.htm> (last visited Feb. 9, 2003).

118. Boyle, *supra* note 118, at 437.

119. See M. Audrey Burnam & Jose Escarce, *Equity in Managed Care for Mental Disorders: Benefit Parity Is Not Sufficient to Ensure Equality*, 18 HEALTH AFFAIRS 22 (1999); Richard Frank & Thomas McGuire, *Parity for Mental Health and Substance Abuse Care Under Managed Care*, 1 J. MENTAL HEALTH POL'Y & ECON. 153 (1998); Daniel Gitterman, Roland Sturm & Richard Scheffler, *Toward Full Mental Health Parity and Beyond*, 20 HEALTH AFFAIRS 68 (2001).

120. See *supra* note 71. See also SGR, *supra* note 4, at 407. "State and local government has been the major payer for public mental health services historically and remains so today. Since the mid-1960s, however, the role of the Federal government has increased" through programs such as the Community Mental Health Block Grant, Community Support programs, the PATH program and the

mental health expenditures, whereas public funding was responsible for 53 percent.¹²¹ As the Surgeon General writes,

[P]ublic sector programs . . . serve as the mental health service “safety net” and “catastrophic insurer” for those citizens with the most severe problems and the fewest resources in the United States. The public sector serves particularly those individuals with no health insurance, those who have insurance but no mental health coverage, and those who exhaust limited mental health benefits in their health insurance.¹²²

To wit, in terms of shaping the delivery of mental health care, public programs such as Medicaid have become increasingly influential, whereas private insurers have had a diminished role in mental health financing in the past decade.¹²³

Moreover, the severity of mental illness and the consequent “greater intensity of services” for the mentally ill results in an average cost for this population two-and-a-half times higher than that for individuals in the private insurance sector.¹²⁴ It thus seems counterintuitive that private-sector parity laws have received far greater attention in mental health legislation than any proposed public-sector reforms: equal, if not more, emphasis should be placed on public-sector reform.

Knowledge Development and Application Program, in addition to Medicare and Medicaid. *Id.* For further discussion of these federal programs, see *infra* Part V.

121. SGR, *supra* note 4, at 417. Included in public spending were Medicaid (19 percent), Medicare (14 percent), state/local expenditures (18 percent) and other (2 percent). See also Michael Sparer & Lawrence Brown, *Uneasy Alliances: Managed Care Plans Formed by Safety-Net Providers*, 19 HEALTH AFFAIRS 23 (2000).

122. SGR, *supra* note 4, at 407.

123. *Id.* at 417.

124. *Id.* at 419.

Nearly 12 percent of U.S. adults (27 million low-income individuals on public support) receive Medicaid coverage ...With per capita expenditures of \$481 a year for mental health services, the average cost of this coverage is 2.5 times higher than that in the private sector. An explanation for this higher average cost is the severity of illness of this population and greater intensity of services to meet their needs. *Id.* Furthermore, because of the high costs for the severely mentally ill receiving public assistance, the dollar amount available to those who are publicly assisted and suffer lesser mental disorders is drastically reduced. *Id.* “[O]nly about \$40 per year per capita is available for those uninsured with less severe mental illness.” *Id.*

B. The Disproportionate Minority Reliance on Public Programs for Mental Health Services

Racial and ethnic minorities are comparatively overrepresented in public sector health programs.¹²⁵ Based on figures from the U.S. Census Bureau and reported in MHCRC, minorities are, on average, more likely than whites to be enrolled in Medicaid or similar government-funded health programs.¹²⁶ Furthermore, minorities have less adequate health insurance coverage (including mental health parity) than whites¹²⁷ and are more likely to lack insurance coverage entirely.¹²⁸ This intimates a proportionally heavier reliance on government financing among minority communities for mental health costs. In 1998, SAMHSA anticipated that more than half of all African-Americans and Native Americans would use public insurance to pay for inpatient mental health treatment, compared to 34 percent of whites.¹²⁹ However, because African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders and Hispanic Americans do not utilize the de facto mental health service system at a rate equivalent to that of whites,¹³⁰ it is difficult to assess the proportional share of annual mental health care costs attributable

125. See Rosenbaum & Rousseau, *supra* note 58, at 29. The Surgeon General maintains that the disproportionate dependence on governmental assistance among minority communities stems from a history of cultural oppression, resulting in lesser available resources: "In fact, poverty is caused in part by a historical legacy of racism and discrimination against minorities." MHCRC, *supra* note 6, at 40. See *supra* Part I(B)(1)(b); see also W. Michael Byrd & Linda A. Clayton, *Racial and Ethnic Disparities in Healthcare: A Background and History*, in UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE 455 (Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson eds., 2003).

126. MHCRC, *supra* note 6, at 63, 91, 117-18, 141-42.

127. For example, "[b]ecause African Americans are more often employed in marginal jobs, the rate of employer-based coverage among African Americans is substantially lower than the rate among employed whites (53% versus 73%)." MHCRC, *supra* note 6, at 63 (citations omitted).

128. "The 3-year average (1997-1999) shows that 27.1 percent of American Indians and Alaska Natives were without [health insurance] coverage, compared with [34.3 percent for Hispanics], 21.6 percent for Blacks, 20.9 percent for Asians and Pacific Islanders, and 11.6 percent for White non-Hispanics." U.S. CENSUS BUREAU, *supra* note 15, at 7.

129. *Id.*

130. MHCRC, *supra* note 6, at 28.

to these groups.¹³¹ Nonetheless, if racial and ethnic minorities were not as constrained as whites in using mental health services, government spreadsheets would likely reflect more spending on the mental health needs of minorities than on those of whites. That is, the public mental health service 'safety net' would catch more minorities than whites, per capita.

If public programs such as Medicaid account for the majority of mental health costs,¹³² and racial and ethnic minorities comprise more of these public expenditures than do whites, lawmakers would be wise to develop policies that address the mental health needs of these minority communities. These policies should not simply expand the benefits of public-sector programs, but should also develop mental health care options for the working poor who fail to qualify for such programs.

VI. COMMUNITY-BASED MENTAL HEALTH PROGRAMS AND THE DIMINISHING FEDERAL FUNDS

In the concluding chapter of *Mental Health: Culture, Race, and Ethnicity*, the Surgeon General presents assorted recommendations for enhancing minority mental health care.¹³³ Among the science-based recommendations, Dr. Satcher encourages expansion in the areas of epidemiological,¹³⁴ psychopharmacological¹³⁵ and evidence-based treatment research.¹³⁶ Regarding intervention and awareness, he advocates for further community involvement efforts,¹³⁷ more ethnic- or culture-based diagnostic criteria¹³⁸ and innovative strategies for training and providing more minority mental health specialists.¹³⁹ MHCRE also delineates several measures to improve access to

131. See *id.* generally for enumerated reasons minorities are reluctant to utilize mental health services.

132. See *supra* note 71.

133. MHCRE, *supra* note 6, at 159.

134. Meaning the institution of more demographically specific studies. *Id.* at 159-60.

135. *Id.* at 161.

136. *Id.* at 160-61.

137. *Id.* at 166-67.

138. *Id.* at 161-62.

139. *Id.* at 167.

treatment for racial and ethnic minority members, including recommendations to integrate mental health and primary care,¹⁴⁰ augment the geographic location of mental health centers¹⁴¹ and ensure language access for non-English speaking persons.¹⁴² Finally, and of particular relevance to this Comment, is the report's attack on the financial barriers to treatment.¹⁴³ The Surgeon General recommends that new policies be designed to ensure parity and reduce obstacles in managed care,¹⁴⁴ expand public health insurance,¹⁴⁵ and extend health insurance for the uninsured.¹⁴⁶

If there are criticisms to be levied against MHCRE, a lack of constructive policy recommendations is certainly not one of them. Despite the Surgeon General's numerous directives, however, MHCRE offers no blueprint for practical, workable solutions for the disparities in minority mental health care.¹⁴⁷ Expanding community mental health programs is one such solution. Community health centers "are the federal government's principal method of ensuring health care to medically-underserved and low-income populations."¹⁴⁸

140. *Id.* at 163.

141. *Id.* at 162-63.

142. *Id.* at 163.

143. *Id.* at 164.

144. *Id.* See also Kathryn A. Phillips, Michelle L. Mayer & Lu Ann Aday, *Barriers to Care Among Racial/Ethnic Groups Under Managed Care*, 19 HEALTH AFFAIRS 65 (2000).

145. MHCRE, *supra* note 6, at 164.

146. *Id.*

147. See *id.* Mention of the Robert Wood Johnson Foundation program, *Communities in Charge*, is as close as the report comes to submitting a pragmatic solution.

148. OFFICE OF MINORITY HEALTH, NEW STUDY INDICATES COMMUNITY HEALTH CENTERS INCREASE CONTINUITY OF HEALTH CARE FOR RACIAL AND ETHNIC MINORITIES, at <http://www.omhrc.gov/OMH/sidebar/datastats2.htm> (last visited Jan. 21, 2003). Although federal community health centers and programs receive a majority of the national financing and attention, there are countless variations of both government-funded and non-profit community initiatives, including programs specific to the mentally disabled. Examples are The Bureau of Primary Health Care's Community Access Program, available at <http://bphc.hrsa.gov/cap>; The Center for Community Health Research and Action's The Access Project, available at <http://www.accessproject.org/index.htm>; and The National Alliance for the Mentally Ill's Program of Assertive Community Treatment, available at <http://www.nami.org/about/pactstatus.htm>. See also BAZELON CTR. FOR MENTAL HEALTH LAW, 2000 SAMHSA REAUTHORIZATION, at <http://www.bazelon.org/takeaction/alerts/10-17-00samhsa.htm> (last visited Feb.

Not only do community-based treatment centers provide these populations with quality health care, they also improve the continuity of care.¹⁴⁹ For many uninsured, working-poor minorities, community-based centers are often the only means of receiving needed mental health care attention.

While the effectiveness of community mental health centers and programs is largely positive,¹⁵⁰ advocates maintain that the financial forecast is not so. According to the National Mental Health Association, community-based mental health services are underfunded, and federal mental health funding is in jeopardy.¹⁵¹ This trend in federal cost-cutting has a trickle-down effect on mental health services in the community. "Inadequate federal funding is exacerbating a crisis in community mental health at the state and local levels, where budget shortfalls are leading to drastic cuts in vital mental health programs."¹⁵² If the federal budget continues to reduce spending on

9, 2003)(cataloguing important, federally funded community mental health programs).

149. See OFFICE OF MINORITY HEALTH, *supra* note 149. See also Rosenbaum, *supra* note 14. "Only in the case of the federally funded community health centers program does one find federal policies aimed at engendering...careful self-examination by health providers on an ongoing basis to determine whether access to care is appropriate." *Id.* at 691.

150. See NAT'L MENTAL HEALTH ASS'N, COMMUNITY-BASED MENTAL HEALTH SERVICES IMPROVE LIVES AND SAVE DOLLARS and COMMUNITY-BASED MENTAL HEALTH WORKS, both at <http://www.nmha.org/federal/appropriations/index.cfm> (last visited Jan. 21, 2003).

151. For a criticism of President Bush's Budget for FY 2003 in relation to mental health spending, see Legislative Alert, Nat'l Mental Health Ass'n, Budget Leaves Mental Health System in Peril (Feb. 2002), at <http://www.nmha.org/newsroom/system/lal.vw.cfm?do=vw&rid=385> (last visited Feb. 10, 2003); for FY 2004, see News Release, Nat'l Mental Health Ass'n, FY 2004 Budget Fails to Prioritize Mental Health (Feb. 4, 2003), at <http://www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=484> (last visited Feb. 10, 2003).

152. News Release, Nat'l Mental Health Ass'n, Overburdened Mental Health System is Underfunded (Feb. 4, 2002), at <http://www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=379> (last visited Jan. 18, 2003). President Bush did, however, recently sign into law the Health Care Safety Net Amendments Act (107 P.L. 251), which strengthens the federal Health Centers program and authorizes the Healthy Community Access Program. Both programs have the potential of keeping community-based mental health services afloat.

mental health, it will not be surprising to witness deleterious effects on mentally disabled, working-poor minorities.¹⁵³

CONCLUSION

Mental health advocates are right to applaud legislators for ratifying mental health parity laws. Enacting such laws undoubtedly has a place in advancing access to mental health services for those minorities carrying private insurance.¹⁵⁴ Further, it is conceded that parity advocates and lawmakers do not offer parity legislation as a panacea for all those who are mentally disabled in the United States. Indeed, the high levels of unemployment among the severely mentally ill make parity a moot point for many in this population¹⁵⁵ – nothing short of a nationalized health care system will rectify the larger problem.¹⁵⁶ Yet parity proponents are mistaken to think that parity laws will provide equal coverage for all but the unemployed.¹⁵⁷ Many employed persons with mental disabilities lack health insurance altogether. Lack of access to mental health services is “especially [true] for working poor who do not qualify for public coverage and who work in jobs that do

153. See NAT'L MENTAL HEALTH ASS'N, *supra* note 79. “Society can either invest in community-based services...or pay a greater price through increased hospital and primary care costs, greater reliance on correctional facilities, homelessness, [and] other costs to society, including lost productivity and suicide.” *Id.*

154. *But see* MHCRE, *supra* note 6, at 63. “Provision of insurance benefits with more generous mental health coverage does not increase treatment seeking as much among African Americans as among whites” (citation omitted). *Id.*

155. See NAT'L ALLIANCE FOR THE MENTALLY ILL, *supra* note 23.

156. Assuming, of course, that a nationalized health care plan will include mental health parity provisions. See also Alan Weil, The Medical Security System: A Proposal to Ensure Health Insurance Coverage for All Americans, in Economic and Social Research Institute, *Covering America: Real Remedies for the Uninsured*, 31-33 (2001), for an intriguing alternative proposal to national health coverage. *But see* Cosman, *supra* note 91; Samuel Zuvekas, *Health Insurance, Health Reform and Outpatient Mental Health Treatment: Who Benefits?*, 36 Inquiry 127 (1999)(maintaining that providing widespread insurance coverage will not automatically ensure that mental health treatment needs are met).

157. “Most (75 percent) of the uninsured are members of employed families who cannot afford to purchase insurance coverage.” SGR, *supra* note 4, at 419.

not provide private health coverage.”¹⁵⁸ And it is irrefutable that racial and ethnic minorities are overrepresented within this population.

Thus, parity laws, while a noble notion, are not a sensible or plausible way to provide access to care for working-poor racial and ethnic minorities with mental disabilities. Parity legislation, in effect, attends to a population exclusive of working – and often, nonwhite – poor. Several years ago, the editors of the *Los Angeles Times* duly recognized this fact: “[P]arity laws...primarily help well-insured or well-heeled patients who are often only mildly ill — and the mental health professionals who treat them. A larger, poorer and sicker but far less powerful group of mentally ill Americans has been slighted in the parity debates.”¹⁵⁹ In order to achieve the goals set forth in MHCRE, legislating for expansive community-based mental health programs tailored to working-poor minorities should match lawmakers’ parity efforts. This is an equally constructive, economically credible and socially responsible path for addressing the needs of those who are uninsured and mentally disabled in racial and ethnic minority communities throughout America.

158. MHCRE EXECUTIVE SUMMARY, *supra* note 9, at 16.

159. *Redefining Mental Illness*, L.A. TIMES, Dec. 20, 1999, at <http://www.psychlaws.org/StateActivity/California/LPSed5.htm> (last visited Jan. 14, 2003).

